Mental Welfare Commission for Scotland

Report on announced visit to:
Bellsdyke Hospital, Hope House, Bellsdyke Road, Larbert, FK5 4WS

Date of visit: 5 December 2024

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Hope House is a six-bedded female low secure unit on the site of Bellsdyke Hospital. It provides treatment, support and rehabilitation for women with more complex mental health care needs requiring greater levels of support and supervision.

Additionally, along with other wards in Bellsdyke Hospital, it has access to the on-site bungalows and off-site independent flats that can be accessed for further assessment of independent living skills where required.

On the day of our visit, three individuals were accommodated in the main unit and another person was living in one of the bungalows; there were no delayed discharges.

We last visited this service in December 2023 and made recommendations about carer engagement, person-centred care plans, authorisation of psychotropic medication and environmental issues, including anti-ligature work. The response received from the service was a commitment to increase documentation around carer discussion and engagement. A pre-existing facility on the electronic information system 'Care Partner' could be used to capture this and would be actively promoted.

We heard that behavioural family therapy, which was available on-site, would be considered for all individuals and the decision would be recorded in the care programming approach (CPA) document. Participation in person-centred care planning would be evidenced with monthly audits and psychotropic medication consent and authorisation would be updated and checked at multidisciplinary team (MDT) meetings.

Finally, capital funding to support environmental change had been approved and progress would continue to be reviewed at bi-monthly meetings.

Who we met with

We met with, and reviewed the care of four people, two of whom we met with in person. We had the opportunity to meet with the clinical nurse manager (CNM) and senior charge nurse (SCN) remotely via a Microsoft Teams meeting prior to our visit.

Additionally, we were able to have discussions with medical and nursing staff during the visit and the SCN and deputy senior charge nurse (DSCN) were available throughout the day. We had a feedback meeting at the end of day, which was also attended by the service manager, the occupational therapist (OT), the OT lead, the higher trainee doctor, and the chief and lead nurses.

Commission visitors

Denise McLellan, nursing officer

Sandra Rae, social work officer

What people told us and what we found

We were pleased to hear some extremely positive feedback from individuals who clearly valued the whole team approach to their care. One comment reflected an individual's view of the admission as being crucial to their wellbeing and mental health. "I wouldn't be here without Hope House". They spoke of how the plan of care was tailored to their identified needs and how progression and transition in the low secure environment was being carefully managed, highlighting that they felt the plan was going at the right pace for them.

It was evident that staff had an in-depth knowledge of the individuals they were caring for and were invested in making improvements to the provision of care and treatment. It was also apparent that despite the challenges with the level of complexity associated with this group, a real sense of hope was being maintained.

Individuals understood their rights and told us they were kept informed. We were also told they were fully involved in care planning describing the process where improvement could be measured from earlier in the admission.

Most staff in the team were described as supportive and approachable and there was a general feeling of satisfaction in relation to how care and treatment was delivered by the multidisciplinary team (MDT) and that "they do a good job." We were told that the team had a good understanding of risk but were not afraid to manage this, taking a positive risk-taking approach to "strongly push people while balancing this with their own pace."

Comments offered about the consultant psychiatrist included "fantastic, very involved, kind, fair, listens to you and the best consultant I have had." We were told that although medical reviews were fortnightly, they felt confident that if increased frequency was required, this could be arranged quickly, that they were "just an email or phone call away."

We were also pleased to hear the view that there was positive leadership in the nursing team and the impact this had on care delivery. The consensus from individuals we spoke with was that the ward had a good structure and was fair. We were told that the SCN was "outstanding", "if the ward needs her, she stays beyond her usual working hours" and was committed to ensuring "everyone knows and understands the rules in a calm and collected manner." We heard she was supported well in this role by two deputy senior charge nurses (DSCN) who were described as "always listening to any issues and the team get things sorted as soon as possible." We also heard about other staff members being supportive and showing good humour which helped to "generally brighten the place up."

Care, treatment, support, and participation

Care records

Individual records were located on the electronic health record management system, Care Partner. It held information about assessment, the MDT meeting record, risk assessments, continuation notes, recording of one-to one contacts and mental health care plans. Care records that we reviewed were comprehensive and we could see that staff knew the individuals well and endeavoured to consult them. We found evidence of regular one-to-one contacts which gave clear accounts about an individual's general presentation and their thoughts during these contacts.

Risk assessments and management plans were completed timeously using the functional analysis of care environments document (FACE). We found copies of the FACE risk assessments that detailed historical and current risks. These were up to date and referred to risk management plans and other documentation. We also saw that missing person action plans were reviewed weekly.

We found records of physical health monitoring, with referral to specialist services where needed. There ward had weekly input from the advanced nurse practitioner (ANP) linked to a local GP practice. They could be contacted by phone out with their visits. There was involvement from pharmacy, with evidence of recent medication reviews.

We were told that there was a lack of some psychological therapies. One person said that they had been disappointed not to have received dialectical behavioural therapy (DBT) as it had been understood this would be offered when admitted to the ward. The decider skills therapy was delivered by an assistant psychologist, and a sensory group was facilitated by the occupational therapist (OT) and nursing staff. There was also an art therapist who worked closely with people in the unit.

Care plans were strengths-based, detailed and reviewed regularly. We could see that individuals were involved in the decisions that were made and how the care team supported them in a person-centred way. It was easy to follow the progression of the person and to understand why care plans had changed for individuals, including where additional restrictions had been required and how individuals were informed of the rationale for this.

We had been told by one person that changes were made and plans updated on a laptop following discussion with their named nurse and during reviews. Once the plan was agreed it would be printed out and the completed and signed record of this would be stored on Care Partner. Individuals were offered their own copy for reference if they wished.

We were pleased to learn that there was a sense of ownership about the care plans and were told by individuals that even if they felt overwhelmed at times, they knew that actions and activities behind their progression was supportive.

Multidisciplinary team (MDT)
The MDT consisted of a consultant psychiatrist, medical staff, mental health nurses, health care support workers (HCSW), an OT, activity co-ordinators, a psychology assistant pharmacy and an art therapist.

We were told of the lack of psychological therapies and that this was being considered in a wider review of the clinical model of care that had commenced in April 2024. Psychology input across the site had been under capacity for some time and provision to the ward was currently three sessions weekly from the psychology assistant and a monthly case consultation by a clinical psychologist. Psychology provides a valuable contribution to the MDT and any gap in provision could increase the pressure for psychiatry and nursing.

When reviewing the records, we saw that the structured MDT meeting template generated discussion around care and treatment, discharge planning, recording of attendees and where individuals had participated in meetings and how their wishes were known and considered. MDT meetings occurred fortnightly, and the records were clear and flowed well. We also reviewed CPA meeting minutes. CPA is the framework used to provide structured care for individuals with complex care needs requiring multiagency involvement; everyone in the unit was managed under the CPA arrangement.

A quality improvement initiative was in place which aimed to explore issues where it was considered that some people were becoming “stuck” and their admissions prolonged, as well as identifying training requirements. Analysis tools such as SWOT (strengths, weaknesses, opportunities and threats) and MoSCoW (must have, should have, could have and will not have right now) were used to gain a better understanding and guide development. We were told that stakeholders, including the engagement of individuals who were receiving care and treatment, were encouraged to be involved in this process.

In the interim, the speciality training doctor had set up a Balint group for nursing staff. The goal of a Balint group is to improve and achieve a better understanding of the relationship between an individual and the clinician. The focus is to enhance a professional’s ability to connect and care for the individual as opposed to seeking the right answer to clinical problems. It was hoped that psychology would be able to take this forward in the future. We were told that regular clinical supervision was scheduled, and monthly reflective practice continued to be promoted.

Some improvements had been made to the recruitment and retention of nursing staff, however, there remained four registered mental health nurse (RMN) and two healthcare support workers (HCSW) vacancies. We were told that there had been a 30% reduction in the use of bank staff. One additional DSCN had been recruited to the ward in line with the changes made across NHS Forth Valley in-patient mental health services and this was welcomed.

We asked about contact with relatives and carers and were told that this was maintained via phone calls or when they visited the ward. Although relatives could attend meetings, they did not do so, and it was considered that this was due to other commitments. We were unable to meet any relatives, however, were told that they had been informed of our planned visit.

Use of mental health and incapacity legislation

On the day of the visit all four individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was available on Care Partner.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained who are either capable or incapable of consenting to specific treatments. We found consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all available and in place. T2 certificates had an accompanying consent form with the person's signature, however, we noted that medication prescribed was listed as a drug class instead of identifying the specific medication. Best practice is to specify the actual medications and their purpose on the T2. One T3 did not authorise an 'as required' medication that was included on the Hospital Electronic Prescribing and Medicines Administration system (HEPMA). We discussed this with the SCN and RMO who agreed to remedy this.

Additionally, hard copies to reference consent and authorisation were available in the clinical room.

Recommendation 1:
Managers should ensure that the T2 certificate treatment plan specifies the medications, rather than give broad classes of medication. In addition, the dose of each medication which the person has consented to should be recorded.

The Commission has produced good practice guidance on consent to treatment.[1]

[1] *Consent to treatment good practice guide*: https://www.mwcscot.org.uk/node/230

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We saw from the records that one person had nominated a named person, and we saw an example where another person had revoked theirs. There was discussion around consideration to make a new nomination. Individuals we spoke with had a good understanding of the legislation under which they were being given treatment.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No one was subject to any additional restrictions on the day of our visit, but individuals told us that they had been given the rationale and information on appealing this in the past.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. One individual had completed an advance statement and there was evidence of these having been discussed and promoted in other records.

In relation to awareness and understanding of rights, individuals told us that staff kept them informed. Although not currently using independent advocacy services, we could see from historical records that some individuals had input from Forth Valley Advocacy. Individuals told us they could approach staff to make an online referral if this was needed. We were unable to see any information about independent advocacy on display and the SCN agreed to request new materials from the service as a reminder for individuals.

Activity and occupation

There was a broad range of games and arts and craft activities offered on the unit and across the wider site.

Additionally, there was the physiotherapy gym, horticulture therapy, the freedom and mind choir, indoor bowls, cinema trips and karaoke, where individuals could socialise with others onsite.

We saw activity plans and individuals were supported to complete a weekly programme of activity. We were pleased to see that activity provision was offered over the seven-day period. The ward benefitted from having dedicated activity coordinators as well as input from an art therapist. Individuals were also encouraged to access vocational activity as part of their ongoing rehabilitation, and we were

delighted to hear about one individual who was enjoying their work placement with a local social enterprise that supported women with experience of the justice system.

The physical environment

The ward layout consisted of a large day room incorporating communal dining space and there was a therapeutic kitchen accessible under the supervision of staff. There were several whiteboards with helpful information, and we saw a poster notifying people of our visit. The ward was brightly lit, airy and cheerfully decorated with individuals' artwork.

When we visited last year there were outstanding repairs including a communal shower being out of commission. We were advised that repairs had been completed. Funding had also been agreed for site wide improvements to include anti-ligature work, and a plan was being developed to address this. We were told this continued to be risk assessed given the nature of people's illness and increased risk of harm.

Each individual bedroom contained a sink, but the toilets and showering facilities were communal. The rooms were bright, clean and personalised. From a previous visit, we were aware of a lack of meeting rooms and storage space. Some improvements had been made to create a sensory area, but this room was very small. It was anticipated that the ward could be reconfigured to include en-suite facilities, increased therapeutic areas and meeting facilities as part of the redesign process.

Hope House also benefitted from an enclosed garden area which we viewed from a window. It appeared well maintained and was a pleasant therapeutic space which could be enjoyed by individuals. The hospital grounds were well maintained, and individuals could purchase snacks on site. There was also a grocery store nearby.

Summary of recommendations

Recommendation 1:
Managers should ensure that the T2 certificate treatment plan specifies the medications, rather than give broad classes of medication. In addition, the dose of each medication which the person has consented to should be recorded.

Service response to recommendations

The Commission requires a response to this recommendation within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

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When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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